Nebraska Colon Cancer Screening Program

Fee for Service Schedule - Effective July 1, 2013 through June 30, 2014

(Services payable for MEN and WOMEN age 50 years and above)

NOTE – Separate Enrollment Required

DESCRIPTION OF SERVICES	CPT Codes	Program Rates
New Patient; history, exam, straightforward decision-making (10 min. face-to-face)	99201	$40.45
	99201 *	$24.15
New Patient; *expanded* history, exam, straightforward decision-making; (20 min. face-to-face)	99202	$69.01
	99202 *	$45.94
New Patient; *detailed* history, exam, straightforward decision-making; (30 min. face-to-face)	99203	$99.67
	99203 *	$69.84
New Patient; *comprehensive* history, exam, decision-making of moderate complexity; (45 min. face-to-face) (*Program allowed limit same as 99203*)	99204	$99.67
	99204 *	$69.84
New Patient; *comprehensive* history, exam, decision-making of moderate complexity; (60 min. face-to-face) (*Program allowed limit same as 99203*)	99205	$99.67
	99205 *	$69.84
Established Patient; history, exam, straightforward decision-making; (5 min. face-to-face)	99211	$18.84
	99211 *	$8.39
Established Patient *expanded* history, exam, straightforward decision-making; (10 min. face-to-face)	99212	$40.45
	99212 *	$22.92
Established Patient *detailed* history, exam, straightforward decision-making; (15 min. face-to-face)	99213	$67.60
	99213 *	$46.69
Established Patient *detailed* history, exam, decision-making of moderate complexity; (25 min. face-to-face) (*Program allowed limit same as 99213*)	99214	$67.60
	99214 *	$46.69
Established Patient; *comprehensive* history, exam, decision-making of high complexity; (40 min. face-to-face) (*Program allowed limit same as 99213*)	99215	$67.60
	99215 *	$46.69
Consultation; history, exam, straightforward decision-making; (15 min. face-to-face)	99241	$54.73
	99241 *	$35.05
Consultation; Patient *expanded* history, exam, straightforward decision-making; (30 min. face-to-face) (*Program allowed limit same as 99203*)	99242	$99.67
	99242 *	$69.84
Consultation; *detailed* history, exam, decision-making of low complexity; (40 min. face-to-face) (*Program allowed limit same as 99203*)	99243	$99.67
	99243 *	$69.84
Consultation; *comprehensive* history, exam, decision-making of moderate complexity; (60 min. face-to-face) (*Program allowed limit same as 99203*)	99244	$99.67
	99244 *	$69.84
New Patient; *Initial* comp. prev. med. evaluation & management; history, exam, counseling/guidance, risk factor reduction, ordering of appropriate lab procedures, etc. (Age **50**-64) (*Program allowed limit same as 99203*)	99386	$99.67
	99386 *	$69.84
New Patient Comprehensive (Age 65 & Older) (*Program allowed limit same as 99203*)	99387	$99.67
	99387 *	$69.84
Established Comprehensive Preventive Medicine (Age 50-64) (*Program allowed limit same as 99213*)	99396	$67.60
	99396 *	$46.69
Established Comprehensive Preventive Medicine (Age 65 and Older) (*Program allowed limit same as 99213*)	99397	$67.60
	99397 *	$46.69
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) (ASC Group 2)	45378	$371.60
	45378 *	$199.67
Colonoscopy-Discontinued Procedure (ASC Group 2)	45378-53	$131.69
	45378-53 *	$59.42
Colonoscopy, with or without biopsy, single or multiple (ASC Group 2)	45380	$443.49
	45380 *	$238.95
Colonoscopy, with removal of tumor(s), polyp(s), or other lesions(s), by hot biopsy forceps or bipolar cautery (ASC Group 2)	45384	$440.69
	45384 *	$249.07
Colonoscopy, with removal or tumor(s), polyp(s), or other lesion(s) by snare technique (ASC Group 2)	45385	$499.11
	45385 *	$283.51
Hemorrhoidectomy, by simple ligature	46221	$253.64
	46221 *	$178.59

*THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

TC = Technical Component 26 = Professional Component

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Level IV – Surgical Pathology (colon when procedure is a covered procedure) (RULE: This is an allowable charge only when the procedure to obtain sample is a covered procedure)	88305	$65.41
	88305-TC	$29.94
	88305-26	$35.47
Level V – Surgical Pathology (colon when procedure is a covered procedure) (RULE: This is an allowable charge only when the procedure to obtain sample is a covered procedure)	88307	$273.02
	88307-TC	$194.49
	88307-26	$78.53
Pathology consultation during surgery (colon only)	88329	$53.38
	88329 *	$33.69
Pathology consultation during surgery (colon only); first tissue block, with frozen sections(s) single specimen	88331	$93.61
	88331-TC	$34.56
	88331-26	$59.05
Immunohistochemistry (including tissue immunoperoxidase), each antibody (colon only)	88342	$106.25
	88342-TC	$65.93
	88342-26	$40.32
Hospital Fees related to approved Colon Procedures	00300	Medicaid % Rate
Anesthesia Fees related to approved Colon Procedures	00800	Attachment 1
Ambulatory Surgery Centers related to approved Colon Cancer Screening Procedures (NOTE: Refer to Procedure Code for ASC Group Assignment)	Group 1	$336
	Group 2	$449
	Group 3	$518

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Attachment 1: Anesthesia Rates effective 7/1/2013 through 6/30/2014

Fee Schedule for Anesthesia is based on Medicaid Reimbursement system with unit values rounded to nearest cent. Rates are adjusted annually with the Program's Fiscal Year which runs July 1 through June 30.

Anesthesia Claims Modifiers:

Healthcare providers report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. All claims for anesthesia services must include:

- CPT Code **with Modifier** (see list below)
- Start & Stop Times
- Explanation of Benefits from Primary Insurance (where applicable)

When a physician bills for anesthesia services, the correct procedure code AND modifiers indicate:

- The Physician personally provided services to the individual patient
- The physician provided medical direction for CRNA services and the number of concurrent services directed.

The following modifiers MUST be used by when submitting claims for anesthesia services:

AA – Anesthesia Services performed personally by the anesthesiologist
AD – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX – RNA service; with medical direction by a physician
QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ – CRNA service; without medical direction by a physician

Fee Schedule:

To determine the allowable rate for anesthesia services, add the unit value for the procedure to the number of minutes for the procedure and multiple by the appropriate conversion factor.

(Unit Value + Minutes) x Conversion Factor = Allowable Rate

Unit Value:

CPT Code	AA/QY	QK	QX	QZ
00800*	$44.88	$67.87	$44.58	$44.79
00810*	$74.80	$113.12	$74.30	$74.65

*Anesthesia only covered when the surgical procedure performed is determined to be payable by NCP.

Minutes:
Anesthesia claims must include Start and Stop Times of the Procedure.

Conversion Factors:

AA = $1.73	QX = $0.81
QY = $1.73	QZ = $1.43
QK = $0.86	

(EXAMPLE: CPT 00800-QZ – 68minutes … ($44.79 + 68) x $1.43 = $161.29)

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TC = Technical Component 26 = Professional Component